TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXOMA MEDICAL CENTER (EAST)

Respondent Name
LM INSURANCE CORPORATION

MFDR Tracking Number
M4-18-0823-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 22, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "according to Texas Workers Compensation guidelines, it is the duty of the insurance company to convert the MS-DRG to APR-DRG."

Amount in Dispute: $35,702.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The submitted DRG 982 (EXTENSIVE O.R. PROCEDRUE UNRELATED TO PRINCIPAL DIAGNOSIS W CC) was disallowed as the records do not support ICD-10 coding assignment of the procedure to 0JDK0ZZ (Extraction of Left Hand Subcutaneous Tissue and Fascia, Open Approach). The procedure is an Irrigation & Debridement w/scrub brush of left index finger abscess."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 3, 2016 to November 6, 2016	Inpatient Hospital Services	$35,702.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – DRG CODE CONSIDERED INVALID BASED ON ONE OR MORE OF THE FOLLOWING. 1. INCORRECT DRG VERSION PER STATE FEE SCHEDULE G
   - W3 – DRG CODE CONSIDERED INVALID BASED ON ONE OR MORE
   - X045 – DRG CODE CONSIDERED INVALID BASED ON ONE OR MORE OF THE FOLLOWING. 1. INCORRECT DRG VERSION PER STATE FEE SCHEDULE GUIDELINES. 2. INCORRECT ASSIGNMENT OF ONE OR MORE ICD-9 DIAGNOSIS OR ICD-9 PROCEDURE CODES. 3. DOCUMENTATION FROM MEDICAL RECORDS DOES NOT SUPPORT CODE ASSIGNMENT OF BILLED DRG. PLEASE REVIEW AND SUBMIT CORRECTED BILLING FORM WITH REVISED DRG AND, OR DOCUMENTATION SUPPORTING DRG ASSIGNMENT. (X045)

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

> Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
>
> (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is November 3, 2016 to November 6, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 22, 2017. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the information submitted by the parties, in accordance with the provisions of Texas Labor Code §413.031, the division determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 21, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.